WORKERS' COMPENSATION MEDICAL COSTS

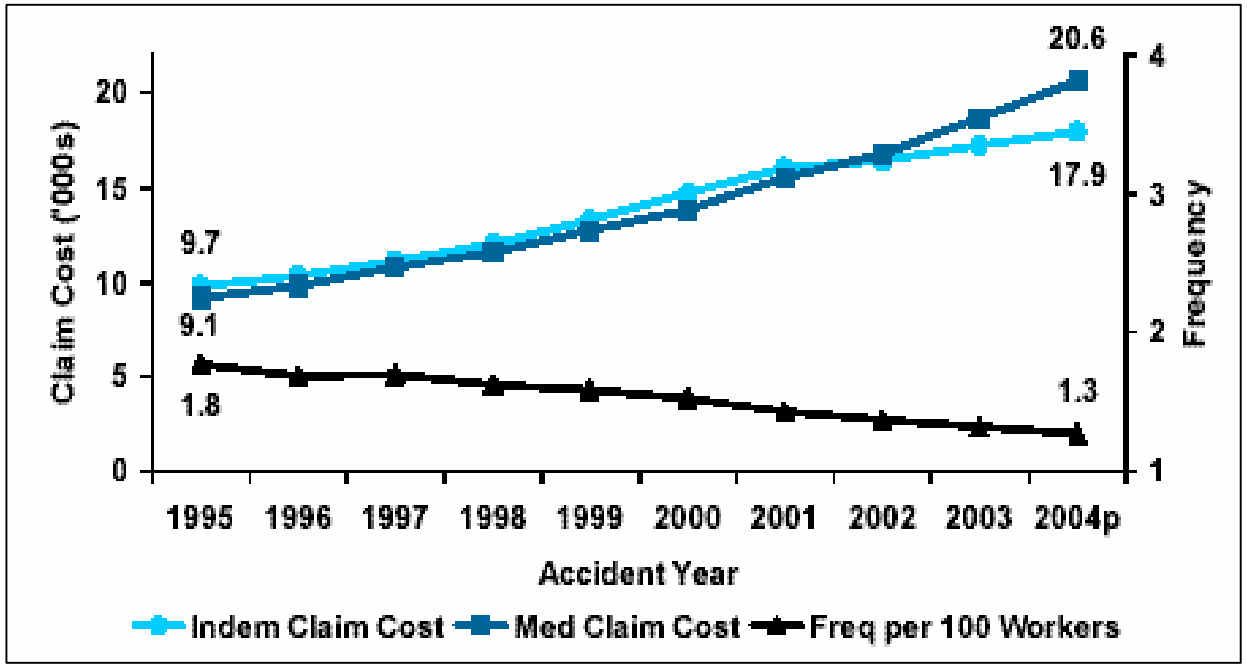
Review of the IAIABC Regulatory Forum on Medical Cost Containment

March 9-11, 2006

Jerry Keck, Administrator
Employment Relations Division

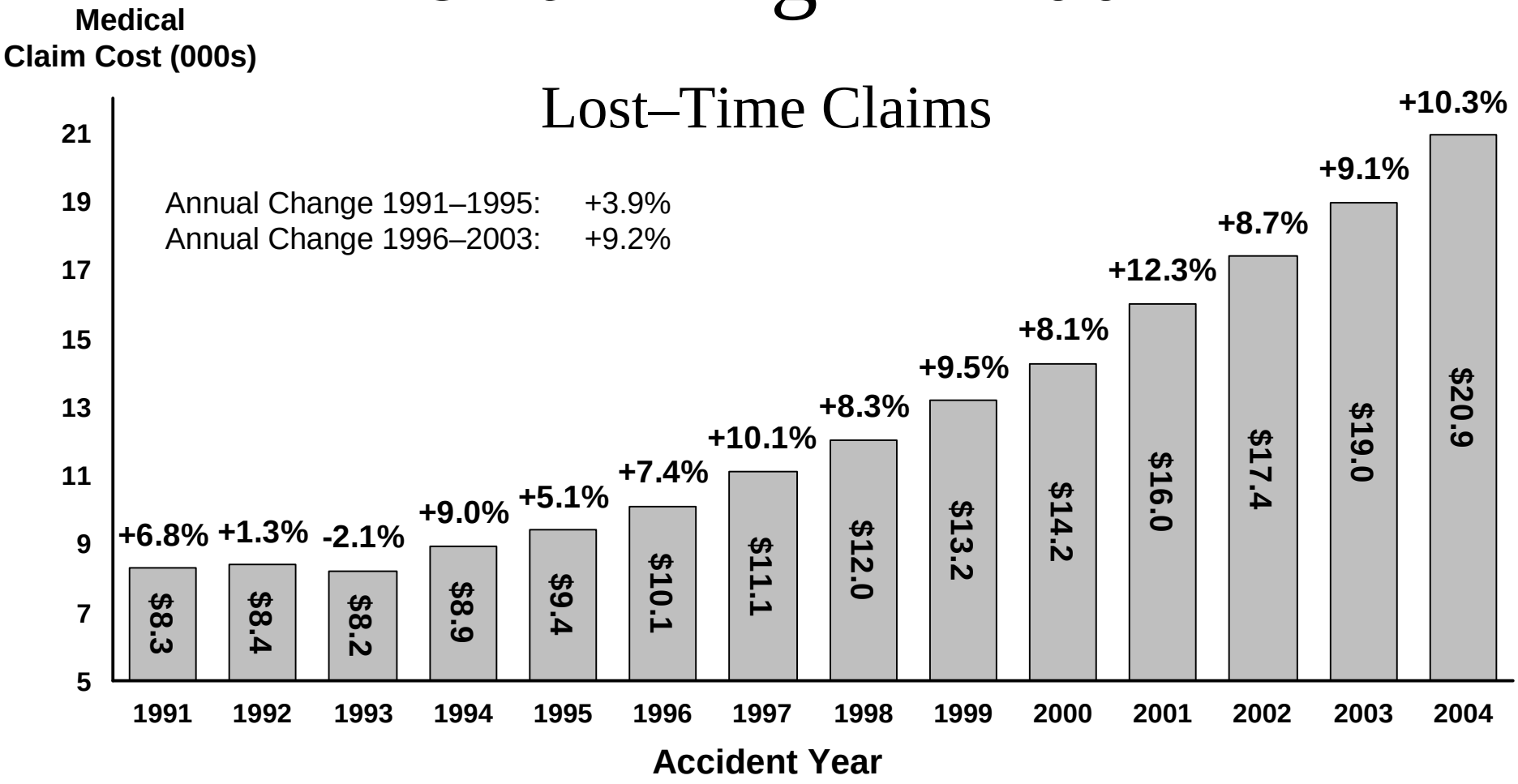
Rising Medical Costs

- Injury rates continue to fall but costs continue to rise



DiDonato T, Brown D "Workers Compensation Claim Frequency Down Again" NCCI Research Brief June 2005

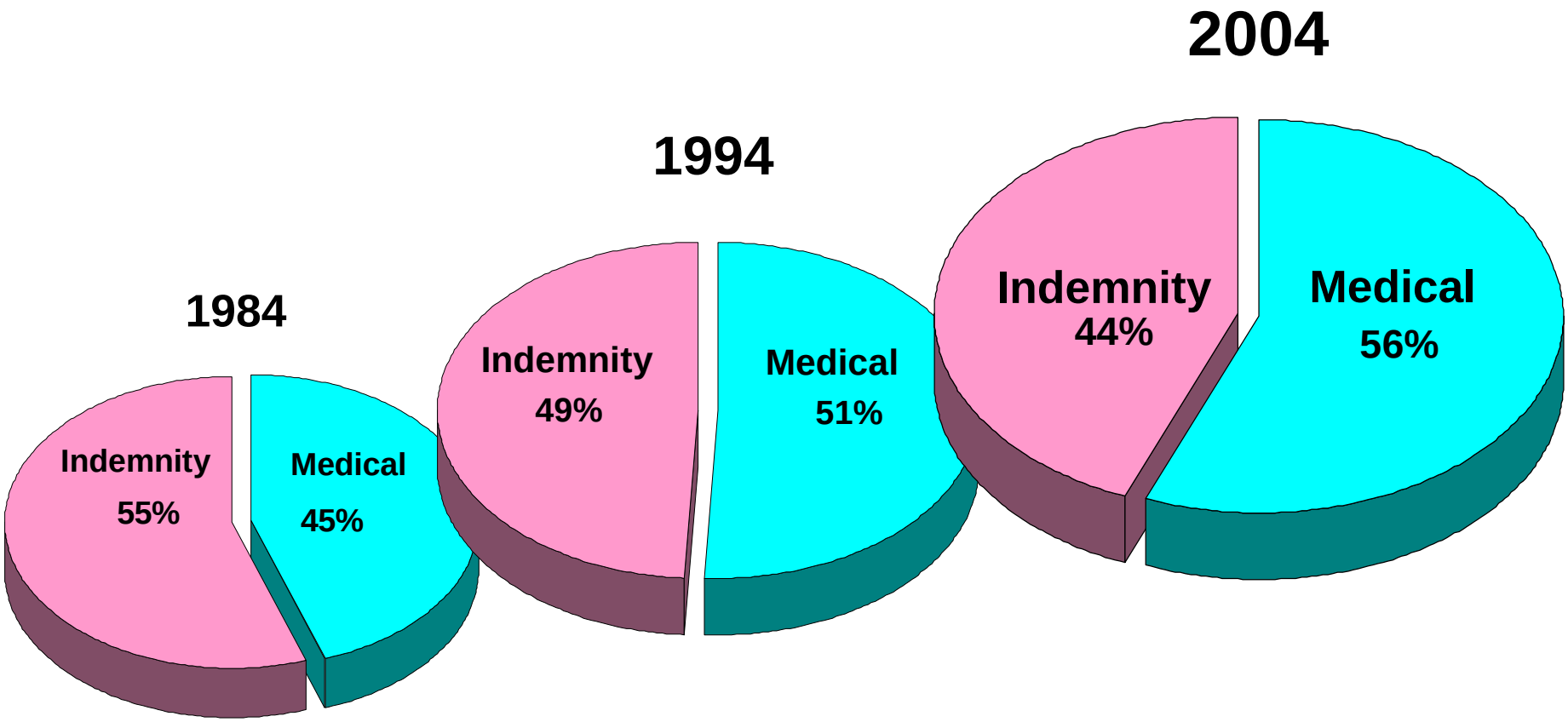
WC Medical Claim Cost Trends Remain High in 2004



1991-2004: Based on data through 12/31/2004, developed to ultimate
Based on the states where NCCI provides ratemaking services
Excludes the effects of deductible policies

Workers Compensation Medical Losses Are More Than Half of Total Losses

All Claims—NCCI States



Based on data through 12/31/2004, developed to ultimate
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Behind Rising Costs

Supply Side "**PUSH**" (*controlling price creep*)

- rising prices

Demand Side "**PULL**" (*controlling appetite*)

- rising utilization
- introduction of new technologies

Supply Side Issues

- Provider Services
- Drug Costs
- Hospital Costs

Medical Payment Categories in Montana

Percentage of WC Medical Payments, Average 1996-2002

Hospital Services	17.1
Complex Surgery and Anesthesia	16.5
Physical Therapy	12.0
Drugs and Supplies	12.0
Office Visits	6.7
Complex Diagnostic Testing	6.3
Diagnostic Radiology	4.9
Surgical Treatments	4.1
Emergency Services	2.5
Pathology	0.7
All Other	17.1

Proposed Study Area
Fee Schedule

Supply Side "**PUSH**"

- fee schedules
  - choosing a schedule – prevailing charges, RVUs, DRGs
  - scope of the schedule – which services, which providers
  - initial price point – relationship to other payment systems
  - allowable inflation – CPI, PPI, "sustainable growth", SAWW

Provider Services

How should fee schedules be gauged?

- wide disparity between states*

  in 2002 from 17% less than Medicare to >200% more

*WCRI Benchmarks for Designing Workers' Compensation Medical Fee Schedules, 2001-2002 Cambridge, MA; 2002

Provider Services

How should fee schedules be gauged?

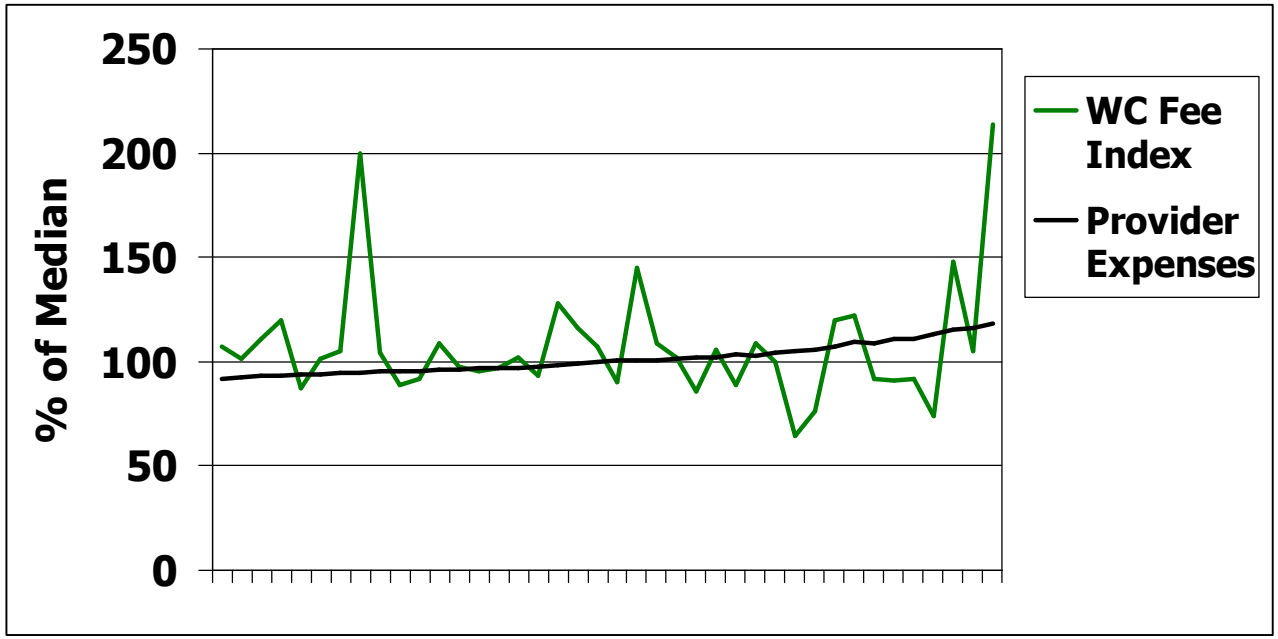
- and within states, differences between classes of services*

  surgery and radiology with larger payments over Medicare than physical medicine and office visits – sometimes as much as 100%

*WCRI Benchmarks for Designing Workers' Compensation Medical Fee Schedules, 2001-2002 Cambridge, MA; 2002

Provider Services

Should fee schedules reflect the provider's cost of doing business?



WCRI Benchmarks for Designing Workers' Compensation Medical Fee Schedules, 2001-2002 Cambridge, MA; 2002

Provider Services

How should workers' compensation compare to other payment systems?

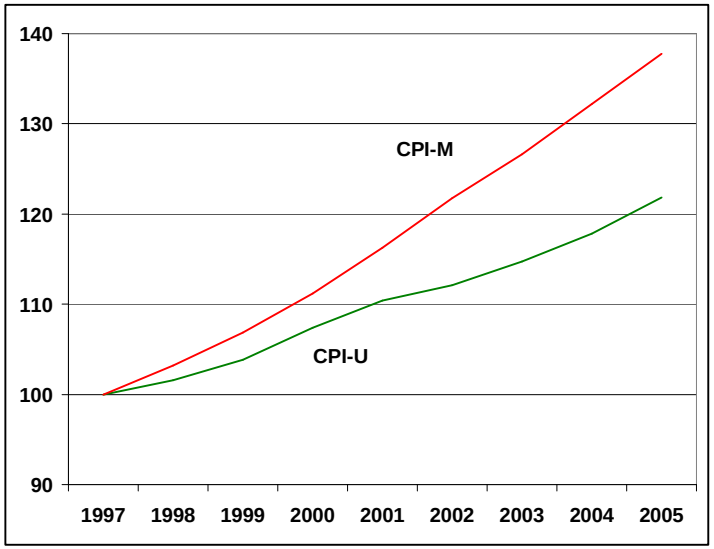
- all but two states with fee schedules pay more than Medicare
- nationally, group health insurers pay ~130% of Medicare[1]

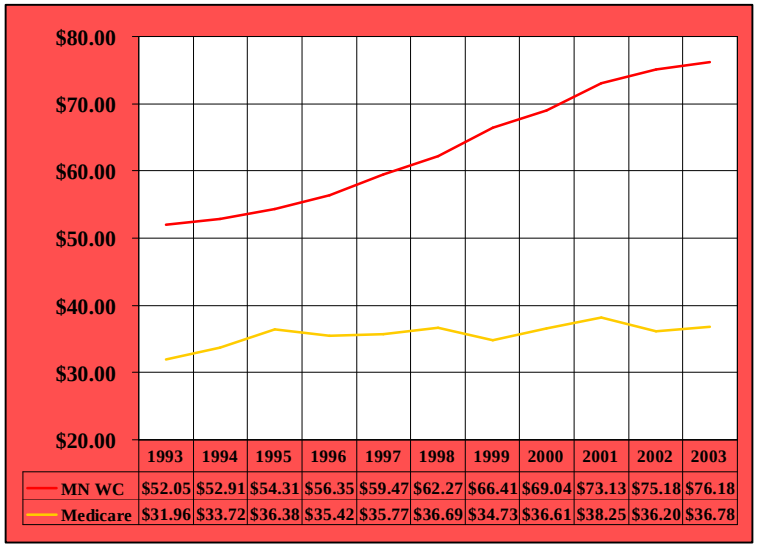
[1]Derived from letter to MN DLI, February 10,2003, signed: Paul S. Sanders, MD, Chief Executive Officer, MMA

Provider Services

Push or Pull…

- supply side
  - Provider charges continue to rise faster than general inflation
  - And reimbursements are higher than other public payors





	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
MN WC	$52.05	$52.91	$54.31	$56.35	$59.47	$62.27	$66.41	$69.04	$73.13	$75.18	$76.18
Medicare	$31.96	$33.72	$36.38	$35.42	$35.77	$36.69	$34.73	$36.61	$38.25	$36.20	$36.78

Research & Statistics, Minnesota Department of Labor and Industry, 2003

Provider Services

Push or Pull…demand side

- Radiology and surgery costs higher because of rapid introduction of new technologies

- Physical medicine costs are higher because of greater utilization and more expensive services

Hospital Charges

A whole lot of push…supply side

Hospital charges risen faster than any other provider's

Hospital Usual & Customary charges are high

More claimants getting service from high-priced hospitals vs. lower-priced providers

Hospital Charges

Can You Justify Cost-Shifting?

- what do others pay? Minnesota data

Hospital Reimbursement in General Health Care - 2001			
	Total Charges	**Total Payments**	**Payment/Charge Ratio**
Medicare	$ 4,647,546,260.00	$ 2,148,770,143.00	46.2%
MA/GAMC/MNCare	$ 1,441,926,499.00	$ 678,672,543.00	47.1%
Private Managed Care	$ 3,022,295,868.00	$ 1,593,265,943.00	52.7%
Commercial./Non-profit Health Plans	$ 2,573,032,139.00	$ 1,679,724,328.00	65.3%
MN Workers Compensation	$ 207,652,941.00	$ 176,505,000.00	85.0%
TOTAL	$ 12,608,778,199.00	$ 6,704,182,843.00	53.2%

We need information for Montana

NCCI Workers Compensation vs. Group Health Medical Cost Study

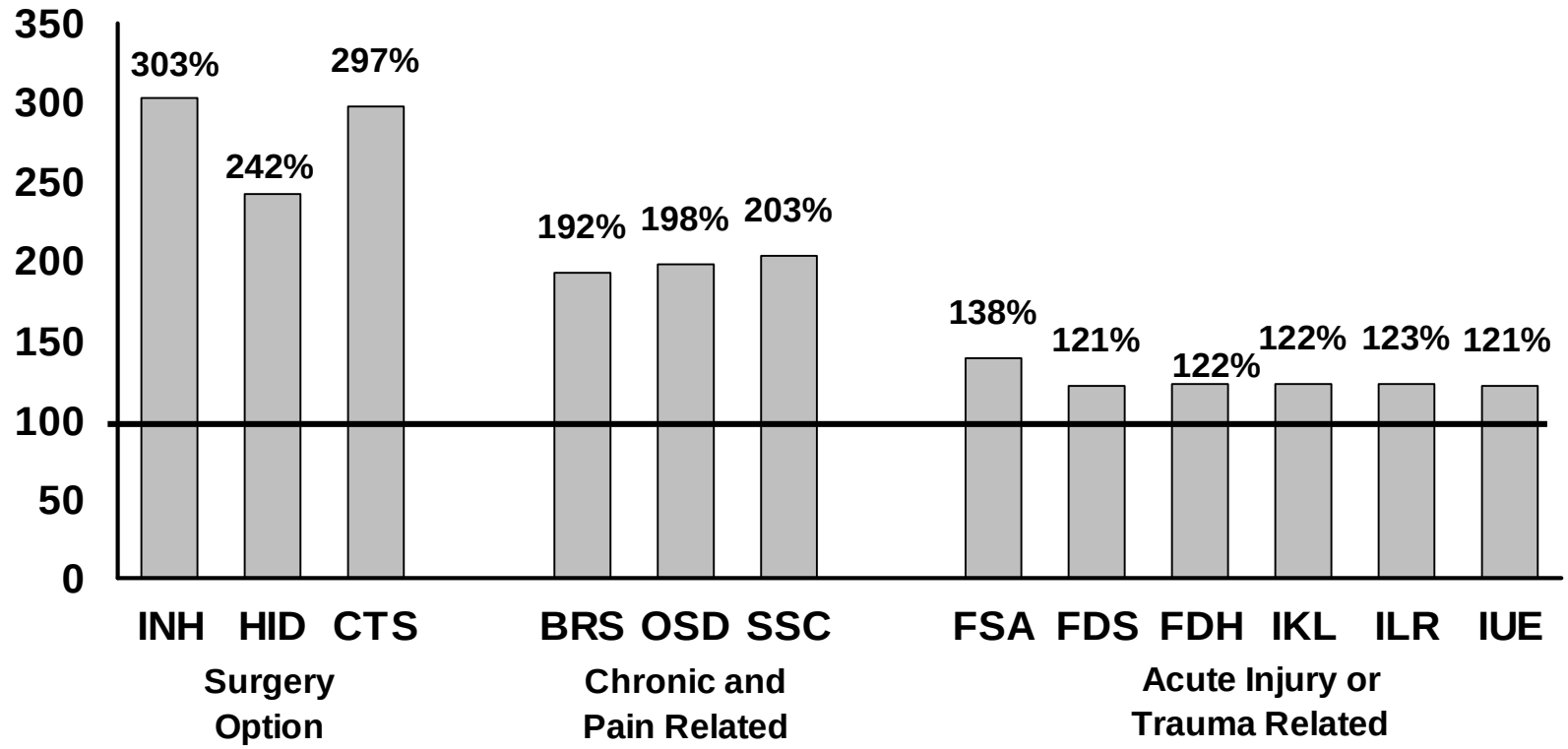
- WC and GH payments were compared between 1997 and 2001 for five states: Florida, Georgia, Illinois, Kentucky and Tennessee
- Prices paid per service for WC are similar to those paid for GH
- WC costs more than GH to treat similar injuries, mostly because of differences in utilization
- WC has more intense and costly treatments earlier on than does GH

Injuries Included in Cost Analysis

Surgery Option	Inguinal hernia (INH)
	Herniated intervertebral disc (HID)
	Carpal tunnel syndrome (CTS)
Chronic and Pain-Related	Bursitis (BRS)
	Other spinal and back disorders (OSD)
	Injury: spine and spinal cord (SSC)
Acute and Trauma-Related	Fracture or sprain: ankle (FSA)
	Fracture, dislocation, or sprain: humerus or shoulder (FDS)
	Fracture, dislocation, or sprain: wrist, hand, or fingers (FDH)
	Injury, knee, ligamentous (IKL)
	Injury, open wound, or blunt trauma: lower extremity (ILE)
	Injury, open wound, or blunt trauma: upper extremity (IUE)

WC/GH Cost Comparison by Injury Group

Within Three Months of Injury
GH = 100%



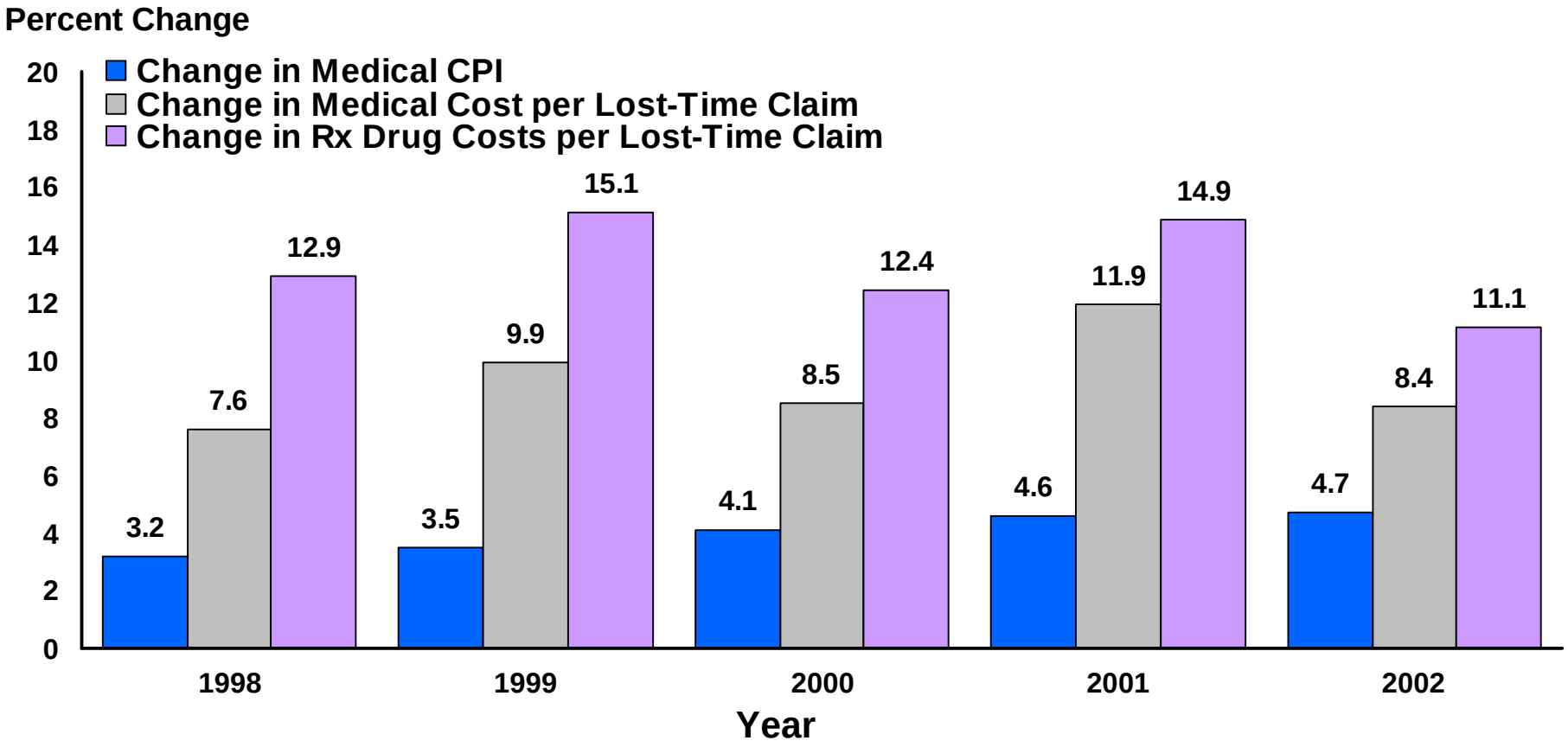
Five-State Average

Proposed Study Area
Drug Costs

Push and Pull…

- supply side
  - Medication prices rising faster than for any other service
  - Most workers' compensation systems pay 100% of sticker price (AWP)
- demand side
  - More patients take more medicines for longer time
  - New very costly brand-name drugs replace older cheap generics

Drug Costs Are Increasing More Rapidly Than Total WC Medical Costs



Medical severity: Based on data through 12/31/2003, developed to ultimate
Based on the states where NCCI provides ratemaking services, excludes the effects of deductible policies
Source: Calendar year medical Consumer Price Index (CPI), Economy.com; Accident year medical severity, NCCI;
Accident year Rx Drug Costs, NCCI estimate based on sample data provided by carriers

Drugs

- Unregulated pricing in US
  - Avistan $100,000 per year for lung cancer patient
  - Canada vs USA pricing?
  - New products and formulations

Source: Douglas Benner, MD, Kaiser Permanente

Drugs

- Direct advertising by pharmacy industry to public
  - US maybe last to allow
  - Drives utilization of new more costly but not necessarily more effective drugs and combinations
- Epidemic of chronic pain and treatment

Source: Douglas Benner, MD, Kaiser Permanente

Top 10 Prescribed Drugs by Total Paid in WC (1997–2002)

	% of Total Rx Paid
Celebrex® (anti-inflammatory)	7.6%
Oxycontin® (painkiller)	6.6%
Vioxx® (anti-inflammatory)	5.6%
Hydrocodone (painkiller)	5.4%
Neurontin® (painkiller)	4.9%
Carisoprodol (muscle relaxant)	3.2%
Ultram® (painkiller)	2.9%
Cyclobenzaprine (muscle relaxant)	2.4%
Ambien® (sedative)	2.1%
Naproxen® (anti-inflammatory)	2.1%

Analgesics comprise 54% of total WC drug bill

Source: NCCI Research Brief, Oct 2004

Negotiating Lower Prices

- Prescription drug fee schedules exist in 28 states
  - All reimburse using average wholesale prices

- WC pays roughly 125% of Average Wholesale Price (including dispensing fee); Group Health pays only 72%

- Total WC drug costs could fall by more than 40% if WC prices matched those of Group Health

Average Wholesale Price (AWP) is an artificial price established by the pharmaceutical industry for each medication. It is used to calculate reimbursements from Medicare and other third parties.

Proposed Study Area
Treatment Guidelines

Demand Side "**PULL**"

- treatment guidelines
  - who decides best practices
  - who enforces best practices, and how
  - managing discontent – the disconnect between satisfaction and outcomes

Some key WC problem areas

- Growth of spine surgery over the last decade (Deyo)
- Expansion of passive physical medicine and other palliative treatments
- Increase in High Cost Claims
- The “Decade of Pain” and the rise of the chronic pain industry
- Remains heavily driven by musculoskeletal care
- “Medicalization” of normal processes such as stress and aging (Hadler)
- Medical dispute resolution primarily legal, not medical

Quality of WC Medical Care

- There is insufficient attention being paid to quality of care for workers' compensation patients

- What kind of quality does this lead to?

1st Annual Montana Workers' Compensation Quality of Care Survey

Medical care delivered to most of our WC claimants is:

1. Better than what they receive from their group health plan (assuming they have one)
2. About the same as what they receive from their group health plan
3. Worse than average group health care

Quality of Care for WC

- There is minimal industry or regulatory focus on this issue
- Most studies of QOC have indicated that better care is cost-beneficial or at worst, cost neutral
- Duration of care for WC injuries may extend for years, or life.
- Many studies suggest treatment outcomes are worse in WC patients c/w group health (e.g., Atlas SJ et al. *JBJS* 2000;82A:4-15).
- Few state systems collecting medical/disability outcomes data, fewer have analyzed in detail
- Outcomes following administrative/judicial proceedings not tracked

Source: David Deitz, MD, National Medical Director, Liberty Mutual. Presentation to IAIABC Medical Institute

QOC – Institute of Medicine Definition

High quality health care should be:

*** Safe - avoiding injuries to patients from the care that is intended to help them.**

*** Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).**

*** Patient-centered - providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.**

*** Timely - reducing waits and sometimes harmful delays for both those who receive and those who give care.**

*** Efficient - avoiding waste, including waste of equipment, supplies, ideas, and energy.**

*** Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.**

IOM: *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press, 2001

Systematic Improvements to Improve Quality of Care in WC

- Continued support for better data, especially treatment outcomes
- Embed evidence-based practice in guidelines
- Create environment for guidelines to work
- Measure
- Seek systematic reform

Systematic Reform

ACOEM Occupational Medicine Practice Guidelines

- American College of Occupational and Environmental Medicine
- Principles of evidence-based medicine
- Intended to ensure that workers receive best medical care as quickly as possible, in most cost-effective manner
- Focused on improving outcomes
- Adopted in California by statute

In Conclusion

Proposed Areas of Study

- Fee Schedules
- Drug Costs
- Treatment Guidelines

Questions or Comments?